ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

CONTRACTOR: ______________________ **DATE RECEIVED:** ______________________

CONTRACTOR CONTACT: ______________________ **PHONE NUMBER:** ______________________

LINES OF BUSINESS: ______________________ **DATE APPROVED:** ______________________

REVIEWER: ______________________ **DATE REVIEWED:** ______________________

The Contractor must complete a separate checklist for each line of business (Acute Care, ALTCS/EPD, DDD, CMDP, CRS, and RBHA). The Contractor must complete column 'C' and may complete column 'F' if applicable.

								CONTRACTOR	AHCCCS		CONTRACTOR	AHCCCS
	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
1.	Readability scale – The Contractor must specify the Flesch-Kincaid reading level in the cover memo/letter when submitting the Handbook for approval	X	X	X	X	X	X					
2.	The handbook revision date	X	X	X	X	X	X					
3.	Table of Contents	X	X	X	X	X	X					

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		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
4.	A statement that covered services are funded under contract with AHCCCS	X	X	X	X	X	X					
5.	The members' right to complain about the managed care organization (AMPM 930, 1, j)	X	X	X	X	X	X					

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6.	How to file a complaint with the Contractor. This must include the member's right to file a complaint to the Contractor regarding the adequacy of Contractor's Notice of Action letters. Further, it must include the member's right to contact AHCCCS Medical Management if the Contractor does not resolve the member's concern of adequacy with the Notice of Action letter	X	X	X	X	X	X					
7.	All grievance and request for hearing information as described in the "Grievance System" section of the contract.	X	X	X	X	X						

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8.	All complaint, grievance and request for hearing information for Members determined SMI			X								
~~8.~~9.	All complaint, grievance and request for hearing information for each group listed below: a. Members eligible for Title XIX/XXI services b. Members determined SMI c. Members not determined SMI and not eligible for Title XIX/XXI services.						X					
~~9.~~10.	The member's right to request information on the structure and operation of the Contractor or its subcontractors [42 CFR 438.10 (g)(3)(i)]	X	X	X	X	X	X					

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~~10.~~11.	A statement that informs the member of their right to request information on whether or not the Contractor has Physician Incentive Plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements the Contractor uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation	X	X	X	X	X	X					
~~11.~~12.	The members' right to be treated fairly regardless of race, religion, gender, age, ability to pay	X	X	X	X	X	X					

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~~12.~~13.	The member's right to be provided information about formulating Advance Directives, as described in AMPM 930	X		X	X	X	X					
~~13.~~14.	Confidentiality and confidentiality limitations	X	X	X	X	X	X					
~~14.~~15.	The members' right to a second opinion from a qualified health care professional within the network, or have a second opinion arranged outside the network, only if there is not adequate in-network coverage, at no cost to the enrollee	X	X	X	X	X	X					

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~~15.~~16.	The members' right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand the information	X	X	X	X	X	X					
~~16.~~17.	The members' right to get a replacement caregiver for "critical services" within two hours			X	X							
~~17.~~18.	The members' right to annually request and receive a copy of his/her medical record and/or inspect medical records at no cost	X	X	X	X	X	X					

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~~18.~~19.	The members' right that the Contractor must reply within 30 days to the member's request for a copy of the medical records. The response may be the copy of the medical record or a written denial that includes the basis for the denial and information about how to seek review of the denial in accordance with 45 CFR Part 164. (AMPM 930.1.iv)	X	X	X	X	X	X					
~~19.~~20.	The members' right to request their medical record be amended or corrected. 45 CFR Part 164	X	X	X	X	X	X					

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~~20.~~21.	The members' right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation	X	X	X	X	X	X					
~~21.~~22.	The members' right to participate in decisions regarding his or her health care, including the right to refuse treatment	X	X	X	X	X	X					
~~22.~~23.	Instructions for obtaining culturally competent materials and/or services, including translated member materials	X	X	X	X	X	X					
~~23.~~24.	The availability of printed materials in alternative formats and how to access such materials	X	X	X	X	X	X					

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~~24.~~25.	The availability of interpretation services for oral information at no cost to the member and how to obtain these services	X	X	X	X	X	X					
~~25.~~26.	The availability of information identifying a network provider's cultural and linguistic capabilities, including languages offered by the provider or a skilled medical interpreter at the provider's office, and how to access that information.	X	X	X	X	X	X					
27.	The availability of information identifying network provider offices that accommodate members with physical disabilities, and how members may access that information.			X								

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~~26.~~28.	**To be included verbatim in the handbook**: List of applicable copayments. (See Attachment B.1.a.)	X	X	X	X	X	X					
~~27.~~29.	**To be included verbatim in the handbook: List of applicable copayments for Non-Title XIX/XXI members. (See Attachment B,1,b)**						X					
~~28.~~30.	What to do if a member is billed, and under what circumstances a member may be billed for non-covered services as specified by AHCCCS.	X	X	X	X	X	X					
~~29.~~31.	**To be included verbatim in the handbook:** Arizona's Vision for the Delivery of Behavioral Health	X		X		X	X					

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	Services (see Attachment B.2)											
~~30.~~32.	**To be included verbatim in the handbook:** Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems (see Attachment B.3)	X		X		X	X					
~~31.~~33.	Contributions the member can make towards his/her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor.	X	X	X	X	X	X					

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~~32.~~34.	Information on what to do when family size or other demographic information change	X	X	X	X	X	X					
~~33.~~35.	Member's share of cost			X	X							
~~34.~~36.	A general description about how managed care works, particularly in regards to member responsibilities, appropriate utilization of services and the PCP's roll as gatekeeper of services	X	X	X	X	X	X					
~~35.~~37.	Information on the use of other sources of insurance. See "Coordination of Benefits and Third Party Liability" in the contract	X	X	X	X	X	X					

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~~36.~~38.	Information that coordination of care with schools and state agencies may occur, within the limits of applicable regulations. [42 CFR 438.10(e)(2)(i)(c)]	X	X	X	X	X	X					
~~37.~~39.	The ability to change Contractors for Continuity of Care reasons should be included (This is not applicable if there is only one Contractor in a GSA)	X		X								
~~38.~~40.	**<u>To be included verbatim in the handbook</u>**: 'Members who are determined to have a Serious Mental Illness and who are enrolled in one plan for both physical health and behavioral health services may request a						X					

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	different plan for their physical health services. This is called an opt-out process. A member can only request to opt-out for certain reasons. To ask for an opt-out, the member must show harm or unfair treatment in: 1. Getting healthcare, 2. Receiving quality healthcare, 3. Protecting member privacy and rights, or 4. Choosing a provider. If you would like to ask for an opt-out, contact member services at [xxx-xxx-xxxx].											

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~~39.~~41.	**<u>To be included verbatim in the handbook</u>**: American Indian members are able to receive health care services from any Indian Health Service provider or tribally owned and/or operated facility at any time.	X	X	X	X		X					
~~40.~~42.	**<u>To be included verbatim in the handbook</u>**: American Indian members are able to receive health care services not related to their CRS condition from any Indian Health Service provider or tribally owned and/or operated facility at any time.					X						
~~41.~~43.	A description of all available covered services	X	X	X	X	X	X					

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~~42.~~44.	Description of all covered dental services	X	X	X	X	X	X					
~~43.~~45.	Description of all covered behavioral health services	X	X	X	X	X	X					
~~44.~~46.	**To be included verbatim:** Medically Necessary Pregnancy Terminations (See Attachment B.4)	x	X	X	X	X	X					
~~45.~~47.	Explanation of the ALTCS Transitional Program and what services are available to members enrolled			X	X							
~~46.~~48.	Detailed descriptions of all current residential placement options			X	X							

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~~47.~~49.	Information on any service limitations or exclusions from coverage. AMPM Exhibits 300-1, 300-2 and , 330-1	X	X	X	X	X	X					
~~48.~~50.	Explanation of when and how the member may request a change of Contractor	X		X		X						
~~49.~~51.	How to contact Member Services and a description of its function	X	X	X	X	X	X					
~~50.~~52.	How to contact the case manager, including information on why and how to contact the Case Manager in between visits			X	X							
~~51.~~53.	An explanation of the Contractor's approval and denial process	X	X	X	X	X	X					

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~~52.~~54.	Advise members that the criteria that decisions are based on are available upon request	X	X	X	X	X	X					
~~53.~~55.	How to obtain, at no charge, a directory of providers	X	X	X	X	X	X					
~~54.~~56.	How to obtain a PCP	X	X	X	X	X	X					
~~55.~~57.	How to change a PCP	X	X	X	X	X	X					
~~56.~~58.	Information regarding dental homes, including specifications that the member can choose or change an assigned dental provider	X	X	X	X	X	X					

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~~57.~~59.	How to make, change, and cancel appointments with a PCP/Provider	X	X	X	X	X	X					
~~58.~~60.	How to obtain emergency transportation and medically necessary transportation	X	X	X	X	X	X					
~~59.~~61.	How to access afterhours care (urgent care)	X	X	X	X	X	X					
~~60.~~62.	How to access behavioral health crisis services. Including crisis services contact information.	X	X	X	X	X	X					
~~61.~~63.	Description of the process for making, changing, or cancelling dental appointments	X	X	X	X	X	X					

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~~62.~~64.	A description of how to obtain pharmacy services after hours/weekends/holidays. In addition, information on what to do if the member is turned away at the Point Of Sale (POS)	X	X	X	X	X	X					
~~63.~~65.	The process of referral and self-referral to specialists and other providers	X	X	X	X	X	X					
~~64.~~66.	How to access covered Behavioral Health services	X	X	X	X	X	X					

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~~65.~~67.	**<u>To be included verbatim in the handbook</u>**: "Your ID card has a phone number to access behavioral health and substance abuse services. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call the number on your card."	X	X		X	X						
~~66.~~68.	How to make, change and cancel appointments with a Multi-Specialty Interdisciplinary Clinic (MSIC)	X	X	X	X	X						
~~67.~~69.	A description of each multispecialty interdisciplinary clinic's specialties	X	X	X	X	X						

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~~68.~~70.	Information on proper utilization of emergency services. It must also state that a member has a right to obtain emergency services at any hospital or other emergency room facility (in or out of network) and that prior authorization is not required.	X	X	X	X	X	X					
~~69.~~71.	A description of the geographic service area(s) served by the Contractor (For DDD this applies to the Acute Subcontractors)	X		X	X		X					
~~70.~~72.	Information on out of country/out of state/out of geographic service area moves	X	X	X	X	X	X					

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~~71.~~73.	**The handbook must state the following verbatim**: Early Periodic Screening, Diagnostic and Treatment (EPSDT) language (See Attachment B.5)	X	X	X	X	X	X					

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~~72.~~74.	**To be included verbatim in the handbook:** Well visits (well exams) such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations. (See EPSDT for well exams for members under 21 years of age)	X	X	X	X	X	X					

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~~73.~~75.	**To be included verbatim in the handbook:** Female members have direct access to preventive and well care services from a gynecologist within the Contractor's network without a referral from a primary care provider.	X	X	X	X	X	X					
~~74.~~76.	Maternity and family planning services. This must include information on the importance of making, keeping appointments, and the availability of postpartum services, and an explanation regarding choosing a Primary Care Obstetrician	X	X	X	X	X	X					

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~~75.~~77.	Family planning benefit coverage is available for both male and female members of reproductive age	X	X	X	X	X	X					
~~76.~~78.	Maternity Care Service Definitions (AMPM Policy 410)	X	X	X	X	X	X					
~~77.~~79.	Information regarding prenatal HIV testing and counseling services	X	X	X	X	X	X					
80.	Explanation of end of life care services.			X								
~~78.~~81.	Explanation of appointment availability standards for members requesting prenatal appointments	X	X	X	X	X	X					

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

								CONTRACTOR	AHCCCS		CONTRACTOR	AHCCCS
	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
~~79.~~82.	A definition of member fraud and abuse with reference to penalty for fraud and abuse under law	X	X	X	X	X	X					
~~80.~~83.	A description of provider fraud and abuse, including instructions on how to report providers who may be providing unnecessary or inappropriate services	X	X	X	X	X	X					
~~81.~~84.	State that if the member has an Arizona driver's license or state issued ID, AHCCCS will obtain the member's picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). The AHCCCS eligibility verification screen viewed by providers contains the member's picture (if available)	X	X	X	X	X	X					

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

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	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
	and coverage details											

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

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	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
~~82.~~85.	A statement that the member is responsible for protecting his or her ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's eligibility and/or legal action. A sentence shall be included that stresses the importance of members keeping, not discarding, the ID card	X	X	X	X	X	X					
~~83.~~86.	How to contact the CRS Contractor		X		X	X						
~~84.~~87.	Information to facilitate family members as decision-makers in the treatment planning process					X						

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

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	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
~~85.~~88.	Information regarding the unique needs of children with CRS Conditions and the CRS program		X		X	X						
~~86.~~89.	A description of CRS Member Advocacy Council					X						
~~87.~~90.	Dual eligibility (Medicare and Medicaid) services received in and out of the Contractor's network and coinsurance and deductibles. See Section D, "Medicare Services and Cost Sharing" in the contract and ACOM Policy 201 ~~Medicare Cost Sharing for Members Covered by Medicare and Medicaid~~	X	X	X	X	X	X					

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

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		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
~~88.~~91.	Inform Dual eligible members that AHCCCS does NOT pay for any drugs paid by Medicare, or for the cost sharing (coinsurance, deductibles, and copayments) for these drugs. AHCCCS **does not pay** for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare. AHCCCS pays for barbiturates for Medicare members that are **NOT** used to treat epilepsy, cancer, or chronic mental health conditions. See AMPM Policy 310-V, ~~Prescription Medications/ Pharmacy Services~~[1]	X	X	X	X	X	X					

[1] Removing title of Policy

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

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	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
~~89.~~92.	Tobacco Cessation information. This should include, but is not limited to, information regarding the availability/accessibility of community support groups, information regarding the Arizona Smokers Helpline, and how members can seek tobacco cessation treatment, care and services. The following link shall be provided: http://www.azdhs.gov/tobaccofreeaz/	X	X	X	X	X	X					

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

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	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
~~90.~~93.	Information on community resources applicable to the Contractor's population and geographic service area. Examples of resources may include WIC, Head Start, AzEIP, Area Agency on Aging, the Alzheimer's Association, Mentally Ill Kids in Distress (MIKID), AZ Suicide Prevention Coalition, and National Alliance on Mental Illness (NAMI). The following links shall be provided: www.healthearizonaplus.gov www.azlinks.gov	X	X	X	X	X	X					

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW: ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA	CONTRACTOR (C) FOUND ON PAGE:	AHCCCS (D) YES	AHCCCS (E) NO	CONTRACTOR (F) CONTRACTOR COMMENTS	AHCCCS (G) AHCCCS COMMENTS
~~91.~~94.	Information about ALTCS advocates and advocacy systems and how to access those supports. Include at a minimum the following: -Centers for Independent Living -Disability Benefits 101 -Arizona Center for Disability Law -Long Term Care Ombudsman -Legal Aid -Low-income housing services			X	X							

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

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	(A) MEMBER HANDBOOK REQUIREMENTS CONTRACT SECTION D ACOM POLICY 404	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW						(C) FOUND ON PAGE:	(D) YES	(E) NO	(F) CONTRACTOR COMMENTS	(G) AHCCCS COMMENTS
		ACUTE CARE	CMDP	ALTCS/EPD	DDD	CRS	RBHA					
~~92.~~95.	Information about behavioral health advocates and advocacy systems and how to access those supports. Examples may include: - Arizona Center for Disability Law – Mental Health - NAMI - Arizona Coalition Against Sexual and Domestic Violence	X	X	X	X	X	X					
~~93.~~96.	Advocacy Information, including how services are obtained	X	X	X	X	X	X					

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ACOM POLICY 404, ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

ATTACHMENT B.1.a.

COPAYMENTS

Some people who get AHCCCS Medicaid benefits are asked to pay copayments for some of the AHCCCS medical services that they receive.

*NOTE: Copayments referenced in this section means copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

THE FOLLOWING PERSONS ARE NOT ASKED TO PAY COPAYMENTS:

- People under age 19,
- People determined to be Seriously Mentally Ill (SMI),
- An individual eligible for the Children's Rehabilitative Services program under A.R.S. §36-2906(E),
- Acute care members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year,
- People who are enrolled in the Arizona Long Term Care System (ALTCS),
- People who are Qualified Medicare Beneficiaries,
- People who receive hospice care,
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs,
- People in the Breast and Cervical Cancer Treatment Program (BCCTP),
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age,
- People who are pregnant and throughout postpartum period following the pregnancy, and
- Individuals in the adult Group (for a limited time**).

**NOTE: For a limited time persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult

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Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

IN ADDITION, COPAYMENTS ARE NOT CHARGED FOR THE FOLLOWING SERVICES FOR ANYONE:

- Hospitalizations,
- Emergency services,
- Family Planning services and supplies,
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women,
- Preventive services, such as well visits, pap smears, colonoscopies, mammograms and immunizations,
- Provider preventable services, and
- Services received in the emergency department.

PEOPLE WITH OPTIONAL (NON-MANDATORY) COPAYMENTS

Individuals eligible for AHCCCS through any of the programs below may be charged non-mandatory copays, unless:

1. They are receiving one of the services above that cannot be charged a copay, or
2. They are in one of the groups above that cannot be charged a copay.

Non-mandatory copays are also called optional copays. If a member has a non-mandatory copay, then a provider cannot deny the service if the member states that s/he is unable to pay the copay. Members in the following programs may be charged non-mandatory copay by their provider:

- AHCCCS for Families with Children (1931),
- Young Adult Transitional Insurance (YATI) for young people in foster care,
- State Adoption Assistance for Special Needs Children who are being adopted,
- Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled,
- SSI Medical Assistance Only (SSI MAO) for individual who are age 65 or older, blind or disabled,
- Freedom to Work (FTW).

Ask your provider to look up your eligibility to find out what copays you may have. You can also find out by calling [HEALTH PLAN NAME] member services. You can also check the [HEALTH PLAN NAME] website for more information.

AHCCCS members with non-mandatory copays may be asked to pay the following non-mandatory copayments for medical services:

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OPTIONAL (NON-MANDATORY) COPAYMENT AMOUNTS FOR SOME MEDICAL SERVICES

SERVICE	COPAYMENT
Prescriptions	$2.30
Out-patient services for physical, occupational and speech therapy	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$3.40

Medical providers will ask you to pay these amounts but will **NOT** refuse you services if you are unable to pay. If you cannot afford your copay, tell your medical provider you are unable to pay these amounts so you will not be refused services.

PEOPLE WITH REQUIRED (MANDATORY) COPAYMENTS

Some AHCCCS members have required (or mandatory) copays unless they are receiving one of the services above that cannot be charged a copay or unless they are in one of the groups above that cannot be charged a copay. Members with required copays will need to pay the copays in order to get the services. Providers can refuse services to these members if they do not pay the mandatory copays. Mandatory copays are charged to persons in Families with Children that are no Longer Eligible Due to Earnings - also known as Transitional Medical Assistance (TMA)

Adults on TMA have to pay required (or mandatory) copays for some medical services. If you are on the TMA Program now or if you become eligible to receive TMA benefits later, the notice from DES or AHCCCS will tell you so. Copays for TMA members are listed below.

REQUIRED (MANDATORY) COPAYMENT AMOUNTS FOR PERSONS RECEIVING TMA BENEFITS

SERVICE	COPAYMENT
Prescriptions	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient Non-emergency or voluntary surgical procedures	$3.00

Pharmacists and Medical Providers can refuse services if the copayments are not made.

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5% LIMIT ON ALL COPAYMENTS

The amount of total copays cannot be more than 5% of the family's total income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December.) The 5% limit applies to both nominal and required copays.

AHCCCS Administration will track each member's specific copayment levels to identify members who have reached the 5% copayment limit. If you think that the total copays you have paid are more than 5% of your family's total quarterly income and AHCCCS has not already told you this has happened, you should send copies of receipts or other proof of how much you have paid to *AHCCCS, 801 E. Jefferson, Mail Drop 4600, Phoenix, Arizona 85034.*

If you are on this program but your circumstances have changed, contact your local DES office to ask them to review your eligibility. Members can always request a reassessment of their 5% limit if their circumstances have changed.

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ATTACHMENT B.1.b.
COPAYMENTS FOR NON-TITLE XIX/XXI MEMBERS

Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) may have to pay copayments for behavioral health services. The copayment amount is $3. Prior to your appointment for services, [insert RBHA name] or your provider will discuss with you any payments you will have to pay.

If you have Medicare or private insurance, you will pay the $3 copayment for services covered by [insert RBHA name], or the copayment that your insurance requires (if it is less than $3) for those services. In other words, you will not have to pay a higher payment for [insert RBHA] covered services, just because you have other insurance. However, if you are getting services through your insurance for services or medications that [insert RBHA name] does not cover (see the Available Services Matrix on page [RBHA to insert page number]); you will be responsible for paying the copayment or other fees that your insurance requires.

You may have to pay for non-covered services. Examples of non-covered services may include:

1. A service that your provider did not set up or approve,
2. A service that is not listed on the Available Services Matrix on page [RBHA to insert page number], or
3. A service that you receive from a provider outside of the provider network without a referral.

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ATTACHMENT B.2

ARIZONA'S VISION FOR THE DELIVERY OF BEHAVIORAL HEALTH SERVICES

All behavioral health services are delivered according to the following system principles. AHCCCS supports a behavioral health delivery system that includes:

1. Easy access to care,
2. Behavioral health recipient and family member involvement,
3. Collaboration with the Greater Community,
4. Effective Innovation,
5. Expectation for Improvement, and
6. Cultural Competency.

THE TWELVE PRINCIPLES FOR THE DELIVERY OF SERVICES TO CHILDREN:

1. Collaboration with the child and family:
   a. Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes, and
   b. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. Functional outcomes:
   a. Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
   b. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. Collaboration with others:
   a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
   b. Client-centered teams plan and deliver services, and
   c. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's DCS and/or DDD caseworker, and the child's probation officer.

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d. The team:
   i. Develops a common assessment of the child's and family's strengths and needs,
   ii. Develops an individualized service plan,
   iii. Monitors implementation of the plan, and
   iv. Makes adjustments in the plan if it is not succeeding.

4. Accessible services:
   a. Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need,
   b. Case management is provided as needed,
   c. Behavioral health service plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided, and
   d. Behavioral health services are adapted or created when they are needed but not available.

5. Best practices:
   a. Behavioral health services are provided by competent individuals who are trained and supervised,
   b. Behavioral health services are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practices."
   c. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class members' lives, especially class members in foster care, and
   d. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting:
   a. Children are provided behavioral health services in their home and community to the extent possible, and
   b. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. Timeliness:
   a. Children identified as needing behavioral health services are assessed and served promptly.

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8. Services tailored to the child and family:
   a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided, and
   b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability:
   a. Behavioral health service plans strive to minimize multiple placements,
   b. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,
   c. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,
   d. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and
   e. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage:
    a. Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and
    b. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence:
    a. Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management, and
    b. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. Connection to natural supports:
    a. The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

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ATTACHMENT B.3

NINE GUIDING PRINCIPLES FOR RECOVERY-ORIENTED ADULT BEHAVIORAL HEALTH SERVICES AND SYSTEMS

1. Respect - Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons in recovery choose services and are included in program decisions and program development efforts - A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole person, while including and/or developing natural supports - A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure - A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one's choice - A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust - A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

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7. Persons in recovery define their own success - A person in recovery − by their own declaration − discovers success, in part, by quality of life outcomes, which may include an improved sense of well being, advanced integration into the community, and greater self determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences - A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. Hope is the foundation for the journey towards recovery - A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

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ATTACHMENT B.4

MEDICALLY NECESSARY PREGNANCY TERMINATIONS

Pregnancy terminations are an AHCCCS covered service only in special situations. AHCCCS covers pregnancy termination if one of the following criteria is present:

1. The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.

2. The pregnancy is a result of incest.

3. The pregnancy is a result of rape.

4. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
   a. Creating a serious physical or behavioral health problem for the pregnant member,
   b. Seriously impairing a bodily function of the pregnant member,
   c. Causing dysfunction of a bodily organ or part of the pregnant member,
   d. Exacerbating a health problem of the pregnant member, or
   e. Preventing the pregnant member from obtaining treatment for a health problem.

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ATTACHMENT B.5

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21.

The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources.

EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in federal law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

Amount, Duration and Scope: The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan."

This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 29 optional and mandatory categories of "medical assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

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